Prompting lifestyle interventions to promote weight loss is safe, effective and patient-centred: Yes

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Obesity is a health risk

New Zealand has the third highest obesity rates in the world, and these rates are projected to increase. Importantly, the obesity epidemic results in at least 3200 lives lost per year and is now the biggest cause of preventable death after smoking. Obesity in adults is associated with type 2 diabetes, ischaemic heart disease, stroke, many cancers including breast, bowel and endometrial cancer, osteoarthritis, sleep apnoea and reproductive abnormalities such as Polycystic Ovary Syndrome. It also impacts on people’s social and psychological well-being. The cost of obesity has been estimated to be between $4 and $9 billion per year.

While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making.

The BACK TO BACK section stimulates debate, with professionals presenting their opposing views regarding a clinical, ethical or political issue.
Weight loss is difficult to achieve

There are a number of strategies available that can help reduce the health impacts of obesity. These can include population-based strategies such as the use of sugar taxes, GST off fruit and vegetables and the use of public sector planning to encourage exercise and reduce sedentary behaviours. There is also a role for the individual patient-centred approach to weight management which can range from intensive behavioural and lifestyle modifications, to the use of medication and in life threatening cases, bariatric surgery. Lifestyle modification in General Practice has been shown to be effective although not as successful as more intensive programmes delivered in trials such as the Diabetes Prevention Studies. A meta-analysis of randomised controlled trials (RCTs) found that diet and exercise programmes combined were clearly superior to diet programmes alone or exercise programmes alone. However, regardless of the programme offered, there are usually a group of patients who do not adhere to the diet and exercise regimen and either do not lose weight or they may even gain additional weight. Programme adherence is most likely with supervised attendance programmes and interventions that offer social support.

Safety

The rates of adverse events in behavioural weight loss programmes are rarely reported. Perceived risks can include rapid weight loss, yo-yo weight loss, and adverse psychological effects. It is therefore important to monitor those who are adhering to a prescribed weight loss programme. However, it should be noted that there is little evidence of any increased risk due to weight loss interventions associated with weight cycling. As noted behavioural weight loss programmes if carried out appropriately are effective. The ethical challenge is whether to prompt patients about their weight. Doctors would be considered negligent if they found a patient had hypertension or hyperlipidaemia that increased the patients risk and yet did not communicate the risks and treatment options to their patients. In the same way it can be argued that in those patients where excessive/ unhealthy weight appears to be present, that an appropriate assessment should be made of the patient’s risk, and if it is apparent that their weight is likely to impact negatively that the doctor has an obligation to raise this with their patient.

Implementation challenges

The biggest barrier for general practice is that the resources need to be available to be able to offer an effective and patient-centred intervention. The Ministry of Health Guidelines suggest this should include time to establish long-term trust relationships with patients, regular reviews of weight management plans and the use of relevant support services to address identified barriers. To ensure equity, general practitioners should develop collaborative partnerships with Māori health providers, Whānau Ora providers and other community-based organisations that provide weight management education and services. In the current primary care environment the time and resources needed are lacking. As a collective it would seem that the solution is not to ignore the risk of excessive weight in our patients but rather to be raising this issue with the funding arm of Te Whatu Ora that urgent intervention is required. Sapere estimated that for each dollar spent tackling obesity the country would gain $5.6 in economic benefit. Funding is urgently needed so that primary care practitioners can feel confident in prompting their patients who have unhealthy weight that they can be offered a safe, effective and patient-centred intervention.

References


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